MDR Tracking Number: M5-04-2012-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 2-10-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The therapeutic exercises, ultrasound, electrical stimulation, durable medical equipment, and patient evaluation from 7/22/03 through 11/18/03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

This Findings and Decision is hereby issued this 28th day of July 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 7/22/03 through 11/18/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 28th day of July 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

June 26, 2004

Re: IRO Case # M5-04-2012

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service 7/29/03 – 12/1/03
2. Explanation of benefits
3. Office notes
4. Operative reports 4/23/03, 9/10/03
5. Physical therapy notes

History

The patient slipped and fell while climbing into a trailer and injured his right shoulder. He ultimately underwent arthroscopic debridement of posterior labral tear and subacromial decompression mini open rotator cuff repair.

This was followed by extensive physical therapy. However, by September 2003 the patient had significant adhesive capsulitis, and he was given manipulation under anesthesia. An orthopedic surgeon prescribed the denied services and DME.

Requested Service(s)
Ther exer, ultrasound, elec strim, dur med equip, patient evaluation, 7/22/03 – 11/18/03

Decision
I disagree with the carrier's decision to deny the requested services.

Rationale
Based on the records provided, and the patient's history, it appears that the physical therapy, including modalities, and DME were medically appropriate, considering the complexity of his shoulder injury. All of the patient's treatment was well within medical norms for his diagnosis and postoperative compliction.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.